HSU | Clinical & Rehabilitation Services

Referral Form - Ultrasound Guided Injections

Patient Personal Details

please include contact details of your patient to allow AECC UC to make contact regarding options

Name

DOB

Telephone number

Email Address

Referral Details

Provisional diagnosis & supporting information

What injection therapy are you requesting?

Steroid Injection ☐

Hydrodilatation ☐

Ganglion Aspiration/Injection ☐

Joint Injection ☐

Plantar Fascia Injection ☐

Achilles Tendon Injection ☐

Barbotage ☐

Relevant previous medical history:

What body part is to be targeted?

Referrer Details

Name:

Profession:

Practice:

Telephone Number:

Email Address:

Referrer Signature:

Please complete patient safety information on the following page

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Does your patient have any known allergies? Y/N ☐☐

If Yes, what are they allergic to?

Does your patient have diabetes? Y/N ☐☐

Does your patient take any blood thinning medication? Y/N ☐☐

If Yes, what medication?

Does your patient have primary open angle glaucoma? Y/N ☐☐

Does your patient have Haemophilia? Y/N ☐☐

Is your patient Pregnant? Y/N ☐☐

Is your patient taking antibiotics? Y/N ☐☐

Has your patient had an injection to the same body part within the last 3 months? Y/N ☐☐

Has the patient had previous surgery to the same body part? Y/N ☐☐

If yes, please provide details:

Please complete this form and send via Egress to: ultrasoundreferrals@aecc.ac.uk

We use the secure emailing system Egress to receive referrals to all our imaging services. You will need an Egress account to register with us.

You can also contact us for help during business hours via the methods below.